2019 Minnesota Health Care Disparities
By Race, Hispanic Ethnicity, Language and Country of Origin

WHO IS MN COMMUNITY MEASUREMENT?

As an independent nonprofit dedicated to empowering health care decision makers with meaningful data, MN Community Measurement (MNCM) is a statewide resource for timely, comparable information on health care costs and quality. Quality measurement in health care delivers value to patients, providers, payers and purchasers and the community.

PURPOSE OF THIS REPORT

While Minnesota consistently ranks as one of the healthiest states in the nation, there continues to be wide variation in health care outcomes across and within certain communities. This report summarizes these variations and identifies opportunities for improvement across race, Hispanic ethnicity, preferred language and country of origin (RELC).

KEY FINDINGS & NOTES

• RACE/ETHNICITY
  • American Indian/Alaskan Native, Black/African American and Hispanic patients have significantly lower rates of optimal care compared to the statewide average in all reported measures.
  • White females have significantly higher rates of optimal care compared to White males in most of the reported measures.
  • American Indian/Alaskan Native and Black/African American patients with diabetes have the lowest rates of HbA1c control.
  • Black/African American and Hispanic patients who have diabetes have significantly lower rates of blood pressure control compared to the statewide average for the Optimal Vascular Care measure.

• PREFERRED LANGUAGE
  • Non-English-speaking Black/African American patients have significantly higher rates of optimal diabetes care, optimal vascular care and optimal asthma control among children compared to English-speaking Black/African American patients.

• COUNTRY OF ORIGIN
  • Black/African American patients born outside of the United States have significantly higher rates of optimal care compared to Black/African American patients born in the United States on a majority of the reported measures.

ACKNOWLEDGEMENTS

This report is possible because of the engagement of several stakeholders who are committed to continuous improvement and recognize the important role measurement plays in helping our community establish priorities and improve together.

MNCM extends our thanks to all medical groups and payers for contributing the data necessary for measurement, to the State of Minnesota for its support through the Statewide Quality Reporting and Measurement System, and to the many members of MNCM committees and workgroups providing ongoing guidance to shape this important work.

REPORT PREPARATION DIRECTION

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Measure Development Specialist

Gunnar Nelson
Health Economist

DIRECT QUESTIONS OR COMMENTS TO support@mncm.org
<table>
<thead>
<tr>
<th>QUALITY MEASURES</th>
<th>RACE</th>
<th>ETHNICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>American Indian/Alaskan Native Asian Black/African American Multi-Race Native Hawaiian/Other Pacific Islander White Hispanic Not Hispanic</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Rate 54.0% Rating ▼ 62.9%</td>
<td>Rate 59.1% Rating ▼ 72.9%</td>
</tr>
<tr>
<td>Optimal Diabetes Care</td>
<td>Rate 25.7% Rating ▼ 47.6%</td>
<td>Rate 32.0% Rating ▼ 43.1%</td>
</tr>
<tr>
<td>Optimal Vascular Care</td>
<td>Rate 47.3% Rating ▼ 67.2%</td>
<td>Rate 55.7% Rating ▼ 59.1%</td>
</tr>
<tr>
<td>Optimal Asthma Control – Adults</td>
<td>Rate 34.1% Rating ▼ 53.5%</td>
<td>Rate 47.6% Rating ▼ 52.0%</td>
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<tr>
<td>Optimal Asthma Control – Children</td>
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<td>Rate 60.2% Rating ▼ 58.3%</td>
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<td>Adolescent Mental Health and/or Depression Screening</td>
<td>Rate 69.0% Rating ▼ 88.7%</td>
<td>Rate 88.1% Rating ▼ 85.0%</td>
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<tr>
<td>Adult Depression: Follow-up at Six Months</td>
<td>Rate 32.1% Rating ▼ 33.6%</td>
<td>Rate 27.1% Rating ▼ 26.9%</td>
</tr>
<tr>
<td>Adult Depression: Response at Six Months</td>
<td>Rate 10.6% Rating ▼ 10.3%</td>
<td>Rate 7.5% Rating ▼ 8.0%</td>
</tr>
<tr>
<td>Adult Depression: Remission at Six Months</td>
<td>Rate 5.4% Rating ▼ 5.6%</td>
<td>Rate 3.8% Rating ▼ 4.0%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 12 Months</td>
<td>Rate 25.2% Rating ▼ 29.4%</td>
<td>Rate 23.2% Rating ▼ 21.6%</td>
</tr>
<tr>
<td>Adult Depression: Response at 12 Months</td>
<td>Rate 7.5% Rating ▼ 8.7%</td>
<td>Rate 6.9% Rating ▼ 7.2%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 12 Months</td>
<td>Rate 4.1% Rating ▼ 4.4%</td>
<td>Rate 3.5% Rating ▼ 3.5%</td>
</tr>
</tbody>
</table>

▼ Below statewide average ● Average ▲ Above statewide average
Race/Ethnicity Summary
2019 Report Year (2018 dates of service)

American Indian/Alaskan Native, Asian, Black/African American, Multi-Race, Native Hawaiian/Other Pacific Islander and Hispanic/Latino patients have significantly lower rates of colorectal cancer screening compared to the race/ethnicity average.

White female patients have significantly higher rates of colorectal cancer screening compared to White male patients.

Statewide average for patients with race/ethnicity information available:
Race average = 71.7%
Ethnicity average = 71.8%
Patients who speak English, Hmong, Somali, Spanish or Vietnamese make up the largest portion of the eligible population.

Patients who speak Hmong, Somali or Spanish have significantly lower rates of colorectal cancer screening compared to the statewide average.
## Country of Origin Summary

### 2019 Report Year (2018 dates of service)

Patients from **Laos, Mexico, Somalia, United States and Vietnam** make up the largest portion of the eligible population.

Patients from **Laos, Mexico and Somalia** have **significantly lower** rates of colorectal cancer screening compared to the statewide average.

**Statewide average for patients with country of origin information available**

### Colorectal Cancer Screening

#### By Country of Origin

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Screening Rate</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laos (N = 5,304)</td>
<td>46.5%</td>
<td></td>
</tr>
<tr>
<td>Mexico (N = 4,449)</td>
<td>47.9%</td>
<td></td>
</tr>
<tr>
<td>Somalia (N = 5,408)</td>
<td>33.9%</td>
<td></td>
</tr>
<tr>
<td>United States (N = 997,035)</td>
<td>72.8%</td>
<td></td>
</tr>
<tr>
<td>Vietnam (N = 3,619)</td>
<td>74.9%</td>
<td></td>
</tr>
<tr>
<td>All Others (N = 39,812)</td>
<td>63.5%</td>
<td></td>
</tr>
</tbody>
</table>

### Statewide Average

- **72.1%**

**Asian patients born in the United States** have **significantly higher** rates of colorectal cancer screening compared to Asian patients born outside the United States.

**Black/African American patients born in the United States** have **significantly higher** rates of colorectal cancer screening compared to Black/African American patients born outside the United States.

**White patients born in the United States** have **significantly higher** rates of colorectal cancer screening compared to White patients born outside the United States.
American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients have significantly lower rates of optimal diabetes care compared to the race/ethnicity average.

Black/African American female and White female patients have significantly higher rates of optimal diabetes care compared to Black/African American males and White males, respectively.

62.5% of American Indian patients are tobacco-free, the lowest of any race group.

54.3% of American Indian patients have a controlled HbA1c (< 8.0), the lowest of any race group.

62.1% of Black/African American patients have a controlled HbA1c (< 8.0), the second lowest of any race group.
English-speaking vs. Non-English-speaking

By Optimal Diabetes Component

<table>
<thead>
<tr>
<th>Blood Pressure Control</th>
<th>English</th>
<th>Non-English</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83.3%</td>
<td>81.4%</td>
</tr>
<tr>
<td>Daily Aspirin Use</td>
<td>English</td>
<td>Non-English</td>
</tr>
<tr>
<td></td>
<td>99.4%</td>
<td>99.4%</td>
</tr>
<tr>
<td>Statin Use</td>
<td>English</td>
<td>Non-English</td>
</tr>
<tr>
<td></td>
<td>88.2%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Tobacco-free</td>
<td>English</td>
<td>Non-English</td>
</tr>
<tr>
<td></td>
<td>83.6%</td>
<td>91.2%</td>
</tr>
<tr>
<td>HbA1c Control</td>
<td>English</td>
<td>Non-English</td>
</tr>
<tr>
<td></td>
<td>70.2%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Optimal Care</td>
<td>English</td>
<td>Non-English</td>
</tr>
<tr>
<td></td>
<td>45.4%</td>
<td>41.7%</td>
</tr>
</tbody>
</table>

Non-English-speaking patients have **significantly lower rates of HbA1c control** compared to English-speaking patients.

English-speaking patients have **significantly lower rates of being tobacco-free** compared to Non-English-speaking patients.

Optimal Diabetes Care

**By Preferred Language**

- **49.2%** English-speaking Asian patients
- **45.8%** Non-English-speaking Asian patients

Patients who speak **English, Hmong, Somali, Spanish or Vietnamese** make up the largest portion of the eligible population.

Patients who speak **Hmong, Somali or Spanish** have **significantly lower rates of optimal diabetes care** compared to the statewide average.

**32.5%** English-speaking Black/African American patients

**41.2%** Non-English-speaking Black/African American patients

Non-English-speaking Black/African American patients have **significantly higher rates of optimal diabetes care** compared to English-speaking Black/African American patients.

*Statewide average for patients with preferred language information available*
**Optimal Diabetes Care**

**Country of Origin Summary**

2019 Report Year (2018 dates of service)

**Born in the U.S. vs. Born Outside the U.S.**

*By Optimal Diabetes Component*

<table>
<thead>
<tr>
<th>Component</th>
<th>Foreign-born</th>
<th>U.S.-born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Control</td>
<td>82.5%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Daily Aspirin Use</td>
<td>99.4%</td>
<td>99.4%</td>
</tr>
<tr>
<td>Statin Use</td>
<td>86.5%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Tobacco-free</td>
<td>91.0%</td>
<td>82.8%</td>
</tr>
<tr>
<td>HbA1c Control</td>
<td>65.2%</td>
<td>70.3%</td>
</tr>
<tr>
<td>Optimal Care</td>
<td>43.8%</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

Patients born outside the United States have **significantly lower rates of HbA1c control** compared to patients born in the United States.

Patients born in the United States have **significantly lower rates of being tobacco-free** compared to patients born outside the United States.

**Patients from India, Laos, Mexico, Somalia and United States make up the largest portion of the eligible population.**

Among these patients, those from Laos, Mexico and Somalia with diabetes have the **lowest rates of optimal care.**

![Graph showing optimal diabetes care by country of origin](image-url)

**American Indian/Alaskan Native patients born in the United States** have **significantly lower** rates of optimal diabetes care compared to American Indian/Alaskan Native patients born outside the United States.

**Black/African American patients born in the United States** have **significantly lower** rates of optimal diabetes care compared to Black/African American patients born outside of the United States.
Optimal Vascular Care
By Race/Ethnicity

- **American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients** have significantly lower rates of optimal vascular care compared to the race/ethnicity average.

- **American Indian/Alaskan Native males, Asian males and White males** have significantly higher rates of optimal vascular care compared to American Indian females, Asian females and White females, respectively.

### By Race/Ethnicity

#### Black/African American

- **Blood Pressure Control**: 73.8% vs. 83.8%
- **Daily Aspirin Use**: 91.6% vs. 92.6%
- **Statin Use**: 89.8% vs. 91.7%
- **Tobacco-free**: 72.0% vs. 82.5%
- **Optimal Care**: 46.7% vs. 61.2%

#### Hispanic Ethnicity

- **Blood Pressure Control**: 79.9% vs. 83.8%
- **Daily Aspirin Use**: 90.0% vs. 92.7%
- **Statin Use**: 90.1% vs. 91.8%
- **Tobacco-free**: 84.7% vs. 82.6%
- **Optimal Care**: 57.4% vs. 61.3%

Statewide average for patients with race/ethnicity information available:
- Race average = 61.2%
- Ethnicity average = 61.3%

- **72.0%** of Black/African American patients are tobacco-free, which is significantly below average.
- **73.8%** of Black/African American patients have optimal blood pressure control which is significantly below average.
- **79.9%** of Hispanic patients have optimal blood pressure control, which is significantly below average.
- **90.1%** of Hispanic patients are on a statin medication, which is significantly below average.
Non-English-speaking patients have **significantly lower rates of blood pressure control** compared to English-speaking patients.

English-speaking patients have **significantly lower rates of being tobacco-free** compared to Non-English-speaking patients.

**Patients who speak English, Hmong, Somali, Spanish or Vietnamese** make up the largest portion of the eligible population.

**Patients who speak Hmong** have **significantly higher rates of optimal vascular care** compared to the statewide average.

**Non-English-speaking Black/African American patients** have **significantly higher rates of optimal vascular care** compared to English-speaking Black/African American patients.

### Optimal Vascular Care

#### By Preferred Language

<table>
<thead>
<tr>
<th>Component</th>
<th>English-speaking (%)</th>
<th>Non-English-speaking (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Control</td>
<td>83.8%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Daily Aspirin Use</td>
<td>92.6%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Statin Use</td>
<td>91.7%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Tobacco-free</td>
<td>82.3%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Optimal Care</td>
<td>61.2%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

**Statewide average for patients with preferred language information available**

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**45.3%**

**English-speaking Black/African American patients**

**61.7%**

**Non-English-speaking Black/African American patients**
Patients from India, Laos, Somalia, United States and Vietnam make up the largest portion of the eligible population.

Among these patients, those from India, Laos and Vietnam have significantly higher rates of optimal vascular care.
American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino adult patients have significantly lower rates of optimal asthma control compared to the race/ethnicity average.

White adult females have significantly higher rates of optimal asthma control compared to white adult males.
Patients who speak English, Hmong, Karen, Somali or Spanish make up the largest portion of the eligible adult population.

Adult patients who speak Hmong, Karen, Somali or Spanish have significantly lower rates of optimal asthma control compared to the statewide average.

English-speaking adult Asian patients have significantly higher rates of optimal asthma control compared to non-English-speaking Asian adult patients.

English-speaking adult White patients have significantly higher rates of optimal asthma control compared to non-English-speaking White adult patients.
Patients from India, Mexico, Somalia, South Korea or the United States make up the largest portion of the eligible adult population.

Adult patients from Mexico and Somalia have significantly lower rates of optimal asthma control compared to the statewide average.

Black/African American adults born in the United States have significantly lower rates of optimal asthma control compared to Black/African American adults born outside the United States.

White adults born in the United States have significantly higher rates of optimal asthma control compared to White adults born outside of the United States.
**Optimal Asthma Control - Children**

*By Race/Ethnicity*

- **White male children** have significantly higher rates of optimal asthma control compared to **white female children**.
- **American Indian/Alaskan Native, Black/African American, and Hispanic/Latino children** have significantly lower rates of optimal asthma control compared to the race/ethnicity average.
- **White male children** have significantly higher rates of optimal asthma control compared to **white female children**.

*Statewide average for patients with race/ethnicity information available*

- Race average = 60.0%
- Ethnicity average = 60.3%
Patients who speak English, Hmong, Karen, Somali or Spanish make up the largest portion of the eligible child population.

Children who speak Hmong, Karen or Spanish have significantly lower rates of optimal asthma control compared to the statewide average.

- **English-speaking Asian children** have significantly higher rates of optimal asthma control compared to non-English-speaking Asian children.
- **English-speaking Black/African American children** have significantly lower rates of optimal asthma control compared to non-English-speaking Black/African American children.
- **English-speaking White children** have significantly higher rates of optimal asthma control compared to non-English-speaking White children.

**Statewide average for patients with preferred language information available**
**OPTIMAL ASTHMA CONTROL - CHILDREN**

*Country of Origin Summary*

2019 Report Year (2018 dates of service)

**Optimal Asthma Control - Children**

*By Country of Origin*

- **Ethiopia** (N = 77): 54.5%
- **Kenya** (N = 99): 52.5%
- **Somalia** (N = 197): 63.5%
- **Thailand** (N = 110): 50.0%
- **United States** (N = 59,631): 59.7%
- **All Others** (N = 901): 61.2%

**White children born in the United States** have **significantly higher** rates of optimal asthma control compared to White children outside the United States.

Patients from **Ethiopia, Kenya, Somalia, Thailand or the United States** make up the largest portion of the eligible child population.

Children from **Thailand** have **significantly lower** rates of optimal asthma control compared to the statewide average.

*Statewide average for patients with country of origin information available*
Adolescent Mental Health and/or Depression Screening
Race/Ethnicity Summary
2019 Report Year (2018 dates of service)

American Indian/Alaskan Native, Black/African American and Hispanic/Latino patients have significantly lower rates of adolescent mental health and/or depression screening compared to the race/ethnicity average.

White female patients and American Indian/Alaskan Native female patients have significantly higher rates of adolescent mental health and/or depression screening compared to White male patients and American Indian/Alaskan Native male patients, respectively.
Patients who speak English, Hmong, Karen, Somali or Spanish make up the largest portion of the eligible population.

Patients who speak Hmong, Somali or Spanish have significantly lower rates of adolescent mental health and/or depression screening compared to the statewide average.

English-speaking White patients have significantly higher rates of adolescent mental health and/or depression screening compared to non-English-speaking White patients.

English-speaking Asian patients have significantly higher rates of adolescent mental health and/or depression screening compared to non-English-speaking Asian patients.
Patients from Ethiopia, Kenya, Somalia, Thailand and the United States make up the largest portion of the eligible population.

Patients from Ethiopia, Kenya and Somalia have significantly lower rates of adolescent mental health and/or depression screening compared to the statewide average.
American Indian/Alaskan Native, Asian, Black/African American and Hispanic/Latino patients have significantly lower rates of depression follow-up, response and remission at six months compared to the race/ethnicity averages.

White female patients have significantly higher rates of depression follow-up, response and remission at six months compared to White male patients.
# Adult Depression: Six Month Measures

**Preferred Language Summary**

2019 Report Year (2016 - 2018 dates of service)

<table>
<thead>
<tr>
<th>Preferred Language</th>
<th>Follow-up at Six Months</th>
<th>Response at Six Months</th>
<th>Remission at Six Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>39.7%</td>
<td>4.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>English</td>
<td>35.8%</td>
<td>14.8%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Hmong</td>
<td>37.2%</td>
<td>5.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Somali</td>
<td>26.7%</td>
<td>11.1%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Spanish</td>
<td>30.5%</td>
<td>9.5%</td>
<td>6.1%</td>
</tr>
<tr>
<td>All Others</td>
<td>36.4%</td>
<td>12.1%</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

**Statewide, English-speaking patients have significantly higher rates of response to depression treatment at six months compared to non-English-speaking patients.**

**Statewide, English-speaking patients have significantly higher rates of remission at six months compared to non-English-speaking patients.**

Patients who speak Arabic, English, Hmong, Somali or Spanish make up the largest portion of the eligible population.

Patients who speak Somali are significantly below the statewide average for follow-up at six months; however, the response and remission rates at six months are average.

Patients who speak Spanish are significantly below the statewide average for both follow-up at six months and response to treatment at six months.
Patients from Iraq, Laos, Mexico, Somalia or the United States make up the largest portion of the eligible population.

Patients from Somalia are significantly below the statewide average for follow-up at six months; however, the response and remission rates at six months are average.

Patients from Laos are significantly below the statewide average for both response to treatment and remission at six months.
ADULT DEPRESSION: 12 MONTH MEASURES
Race/Ethnicity Summary
2019 Report Year (2016-2018 dates of service)

Adult Depression: Follow-up at 12 Months
By Race/Ethnicity

![Graph showing follow-up rates by race/ethnicity]

American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients have significantly lower rates of depression follow-up, response and remission at 12 months compared to the race/ethnicity averages.

White female patients have significantly higher rates of depression follow-up, response and remission at 12 months compared to White male patients.

Black/African American female patients have significantly higher rates of follow-up at 12 months compared to Black/African American male patients.

Adult Depression: Remission at 12 Months
By Race/Ethnicity

![Graph showing remission rates by race/ethnicity]

Statewide average for patients with race/ethnicity information available
Race average = 8.0%
Ethnicity average = 8.1%
Adult Depression: 12 Month Measures
By Preferred Language

<table>
<thead>
<tr>
<th>Preferred Language</th>
<th>Arabic</th>
<th>English</th>
<th>Hmong</th>
<th>Somali</th>
<th>Spanish</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Depression: Follow-up at 12 Months</td>
<td>25.3%</td>
<td>31.2%</td>
<td>32.8%</td>
<td>21.1%</td>
<td>15.6%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Statewide Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31.1%</td>
</tr>
<tr>
<td>Adult Depression: Response at 12 Months</td>
<td>5.2%</td>
<td>13.3%</td>
<td>5.4%</td>
<td>7.8%</td>
<td>5.8%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Statewide Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13.1%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 12 Months</td>
<td>2.9%</td>
<td>8.1%</td>
<td>2.4%</td>
<td>5.0%</td>
<td>3.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Statewide Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Statewide, English-speaking patients have significantly higher rates of follow-up at 12 months compared to non-English-speaking patients.

31.2% English-speaking patients

Statewide, English-speaking patients have significantly higher rates of response to treatment at 12 months compared to non-English-speaking patients.

13.3% English-speaking patients

Statewide, English-speaking patients have significantly higher rates of remission at 12 months compared to non-English-speaking patients.

7.4% Non-English-speaking patients

8.1% English-speaking patients

3.8% Non-English-speaking patients

Patients who speak Arabic, English, Hmong, Somali or Spanish make up the largest portion of the eligible population.

Patients who speak Spanish are significantly below the statewide average for follow-up, response and remission at 12 months.

While the rate of follow-up at 12 months for patients who speak Hmong is average, these patients have rates that are significantly below average for both response and remission at 12 months.
**Country of Origin Summary**

2019 Report Year (2016 - 2018 dates of service)

### Adult Depression: 12 Month Measures

**By Country of Origin**

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Follow-up at 12 Months</th>
<th>Response at 12 Months</th>
<th>Remission at 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>31.3%</td>
<td>3.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Laos</td>
<td>29.6%</td>
<td>4.8%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Mexico</td>
<td>17.5%</td>
<td>7.4%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Somalia</td>
<td>19.2%</td>
<td>6.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>United States</td>
<td>29.7%</td>
<td>12.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>All Others</td>
<td>27.2%</td>
<td>9.9%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

**Statewide Average**

- Follow-up: 12 months: 29.5%
- Response: 12 months: 12.0%
- Remission: 12 months: 7.2%

**Patients from Iraq, Laos, Mexico, Somalia or the United States** make up the largest portion of the eligible population.

**Patients from Somalia or Mexico** are significantly below the statewide average follow-up, response and remission at 12 months.

**Patients from Laos** are significantly below the statewide average for both response to treatment and remission at 12 months.
### American Indian/Alaskan Native
#### Snapshot Summary
2019 Report Year (2018 dates of service)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Statewide Average</th>
<th>Increase Needed</th>
<th>% to Eliminate Disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening (N = 7,440)</td>
<td>54.0%</td>
<td>71.7%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Optimal Diabetes Care (N = 4,513)</td>
<td>25.7%</td>
<td>45.2%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Optimal Vascular Care (N = 2,111)</td>
<td>47.3%</td>
<td>61.2%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Adults (N = 1,653)</td>
<td>34.1%</td>
<td>53.5%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Children (N = 1,184)</td>
<td>41.6%</td>
<td>60.0%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Adolescent Mental Health and/or Depression Screening (N = 1,415)</td>
<td>69.0%</td>
<td>85.8%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 6 Months (N = 1,457)</td>
<td>32.1%</td>
<td>35.7%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Adult Depression: Response at 6 Months (N = 1,457)</td>
<td>10.6%</td>
<td>14.7%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 6 Months (N = 1,457)</td>
<td>5.4%</td>
<td>8.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 12 Months (N = 1,457)</td>
<td>25.2%</td>
<td>31.1%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Adult Depression: Response at 12 Months (N = 1,457)</td>
<td>7.5%</td>
<td>13.1%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 12 Months (N = 1,457)</td>
<td>4.1%</td>
<td>8.0%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

*Statewide average for patients with race/ethnicity information available*

#### Eliminating Disparities

- **Increase in number of eligible American Indian/Alaskan Native adult patients with optimal asthma control needed to eliminate the disparity in outcomes.**
  - Increase: 326

- **Increase in number of eligible American Indian/Alaskan Native children with optimal asthma control needed to eliminate the disparity in outcomes.**
  - Increase: 223

- **Increase in number of eligible American Indian/Alaskan Native patients with optimal diabetes care needed to eliminate the disparity in outcomes.**
  - Increase: 895
## Asian

### Snapshot Summary

2019 Report Year (2018 dates of service)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rate</th>
<th>Statewide Average</th>
<th>Increase Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening (N = 25,477)</td>
<td>62.9%</td>
<td>71.7%</td>
<td>85.8%</td>
</tr>
<tr>
<td>Optimal Diabetes Care (N = 11,906)</td>
<td>47.6%</td>
<td>53.5%</td>
<td>61.2%</td>
</tr>
<tr>
<td>Optimal Vascular Care (N = 3,304)</td>
<td>67.2%</td>
<td>71.7%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Adults (N = 3,463)</td>
<td>53.5%</td>
<td>53.5%</td>
<td></td>
</tr>
<tr>
<td>Optimal Asthma Control - Children (N = 2,617)</td>
<td>65.9%</td>
<td>60.0%</td>
<td></td>
</tr>
<tr>
<td>Adolescent Mental Health and/or Depression Screening (N = 8,118)</td>
<td>88.7%</td>
<td>85.8%</td>
<td></td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 6 Months (N = 2,581)</td>
<td>33.6%</td>
<td>35.7%</td>
<td></td>
</tr>
<tr>
<td>Adult Depression: Response at 6 Months (N = 2,581)</td>
<td>10.3%</td>
<td>14.7%</td>
<td></td>
</tr>
<tr>
<td>Adult Depression: Remission at 6 Months (N = 2,581)</td>
<td>5.6%</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 12 Months (N = 2,581)</td>
<td>29.4%</td>
<td>31.1%</td>
<td></td>
</tr>
<tr>
<td>Adult Depression: Response at 12 Months (N = 2,581)</td>
<td>8.7%</td>
<td>13.1%</td>
<td></td>
</tr>
<tr>
<td>Adult Depression: Remission at 12 Months (N = 2,581)</td>
<td>4.4%</td>
<td>8.0%</td>
<td></td>
</tr>
</tbody>
</table>

*Statewide average for patients with race/ethnicity information available*

### Eliminating Disparities

Increase in number of eligible Asian patients with an updated colorectal cancer screening needed to eliminate the disparity in screening.
# Black/African American
## Snapshot Summary
2019 Report Year (2018 dates of service)

<table>
<thead>
<tr>
<th>Service</th>
<th>Statewide Average</th>
<th>Eligible Black/African American Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>58.3%</td>
<td>71.7%</td>
</tr>
<tr>
<td>Optimal Diabetes Care</td>
<td>33.8%</td>
<td>45.2%</td>
</tr>
<tr>
<td>Optimal Vascular Care</td>
<td>46.7%</td>
<td>61.2%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Adults</td>
<td>40.0%</td>
<td>53.5%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Children</td>
<td>55.7%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Adolescent Mental Health and/or Depression Screening</td>
<td>84.8%</td>
<td>85.8%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 6 Months</td>
<td>27.1%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Adult Depression: Response at 6 Months</td>
<td>7.5%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 6 Months</td>
<td>3.8%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 12 Months</td>
<td>23.2%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Adult Depression: Response at 12 Months</td>
<td>6.9%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 12 Months</td>
<td>3.5%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

- Statewide average for patients with race/ethnicity information available

### Eliminating Disparities

- **+1,748**
  Increase in number of eligible Black/African American adult patients with optimal asthma control needed to eliminate the disparity in outcomes.

- **+6,282**
  Increase in number of eligible Black/African American patients with an updated colorectal cancer screening needed to eliminate the disparity in screening.

- **+885**
  Increase in number of eligible Black/African American patients with optimal vascular care needed to eliminate the disparity in outcomes.
Eliminating Disparities

Increase in number of eligible Multi-race patients with an updated colorectal cancer screening in order to eliminate the disparity in screening.

Increase in number of eligible Multi-race patients with optimal diabetes care needed to eliminate the disparity in outcomes.

Statewide average for patients with race/ethnicity information available
### Native Hawaiian/Pacific Islander
#### Snapshot Summary
2019 Report Year (2018 dates of service)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Statewide Average</th>
<th>Updated Data Needed to Eliminate Disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening (N = 1,038)</td>
<td>59.1%</td>
<td>71.7%</td>
</tr>
<tr>
<td>Optimal Diabetes Care (N = 462)</td>
<td>43.1%</td>
<td>45.2%</td>
</tr>
<tr>
<td>Optimal Vascular Care (N = 164)</td>
<td>59.1%</td>
<td>61.2%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Adults (N = 221)</td>
<td>52.0%</td>
<td>53.5%</td>
</tr>
<tr>
<td>Optimal Asthma Control - Children (N = 96)</td>
<td>58.3%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Adolescent Mental Health and/or Depression Screening (N = 233)</td>
<td>85.0%</td>
<td>85.8%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 6 Months (N = 101)</td>
<td>29.7%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Adult Depression: Response at 6 Months (N = 101)</td>
<td>12.9%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 6 Months (N = 101)</td>
<td>7.9%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Adult Depression: Follow-up at 12 Months (N = 101)</td>
<td>27.7%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Adult Depression: Response at 12 Months (N = 101)</td>
<td>13.9%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Adult Depression: Remission at 12 Months (N = 101)</td>
<td>5.9%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

- Statewide average for patients with race/ethnicity information available

### Eliminating Disparities

Increase in number of eligible Native Hawaiian/Pacific Islander patients with an updated colorectal cancer screening needed to eliminate the disparity in screening.
Eliminating Disparities

Increase in number of eligible Hispanic adult patients with optimal asthma control needed to eliminate the disparity in outcomes.

Increase in number of eligible Hispanic patients with an updated colorectal cancer screening in order needed to eliminate the disparity in screening.

Increase in number of eligible Hispanic patients with optimal diabetes care needed to eliminate the disparity in outcomes.
DEFINITIONS & METHODOLOGY
MEASURE DEFINITIONS

OPTIMAL DIABETES CARE
The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving all of the following:
- HbA1c less than 8.0 mg/dL
- Blood pressure less than 140/90 mm Hg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- Patient with ischemic vascular disease on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

OPTIMAL VASCULAR CARE
The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed during the measurement period as defined by achieving all of the following:
- Blood pressure less than 140/90 mm Hg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- On daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

OPTIMAL ASTHMA CONTROL - ADULTS
The percentage of adults 18-50 years of age who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving both of the following:
- Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
- Patient not at elevated risk of exacerbation as defined by less than two emergency department visits and/or hospitalizations due to asthma in the last 12 months

OPTIMAL ASTHMA CONTROL - CHILDREN
The percentage of children 5-17 years of age who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving both of the following:
- Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
- Patient not at elevated risk of exacerbation as defined by less than two emergency department visits and/or hospitalizations due to asthma in the last 12 months

COLORECTAL CANCER SCREENING
The percentage of adults ages 50-75 who are up-to-date with the appropriate screening for colorectal cancer. Appropriate screenings include one of the following:
- Colonoscopy during the measurement period or the nine years prior; OR
- Flexible sigmoidoscopy during the measurement year or the four years prior; OR
- CT colonography during the measurement year or the four years prior; OR
- Fecal immunochemical test (FIT)-DNA during the measurement year or the two years prior; OR
- Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year
**MEASURE DEFINITIONS**

**ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING**
The percentage of patients ages 12-17 who were screened for mental health and/or depression at a well-child visit using a specified tool. *Note: Adolescents diagnosed with depression are excluded from this measure.*

**6 MONTH MEASURES**
- **PHQ-9 Follow-up at 6 Months:** The percentage of patients with depression who have a completed PHQ-9 tool within six months after the index event (+/- 30 days)
- **6 Month Response:** The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) six months after the index event (+/- 30 days)
- **6 Month Remission:** The percentage of patients with depression who reached remission (PHQ-9 score less than five) six months after the index event (+/- 30 days)

**12 MONTH MEASURES**
- **PHQ-9 Follow-up at 12 Months:** The percentage of patients with depression who have a completed PHQ-9 tool within 12 months after the index event (+/- 30 days)
- **12 Month Response:** The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) 12 months after the index event (+/- 30 days)
- **12 Month Remission:** The percentage of patients with depression who reached remission (PHQ-9 score less than five) 12 months after the index event (+/- 30 days)
DIRECT DATA SUBMISSION (DDS)

Each of the measures included in this report is collected through a process known as Direct Data Submission (DDS). DDS measures use data submitted directly to MNCM by medical groups and clinics.

Data Collection
Clinic abstractors collect data from medical records either by extracting the data from an electronic medical record (EMR) via data query or from abstraction of paper-based medical records. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed for data transfer to MNCM.

MNCM staff conduct an extensive validation process including pre-submission data certification, post submission data quality checks of all files, and audits of the data source for selected clinics. For medical record audits, MNCM uses NCQA’s “8 and 30” File Sampling Procedure, developed in 1996 in consultation with Johns Hopkins University. For a detailed description of this procedure, see www.ncqa.org. Audits are conducted by trained MNCM auditors who are independent of medical groups and/or clinics. The validation process ensures the data are reliable, complete and consistent.

Eligible Population Specifications
The eligible population for each measure is identified by a medical group on behalf of their individual clinics. MNCM’s 2019 DDS Data Collection Guides provide technical specifications for the standard definitions of the eligible population, including elements such as age.

Numerator Specifications
For DDS measures, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. The numerator is calculated using the clinical quality data submitted by the medical group; this data is verified through MNCM’s validation process.

Calculating Rates
Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNCM which may include some data from clinics located in neighboring states.
RACE, HISPANIC ETHNICITY, LANGUAGE, AND COUNTRY OF ORIGIN ANALYSES

For the nine DDS measures, the race, ethnicity, language, and country of origin data is submitted by medical groups through MNCM’s DDS process. Please refer to the MNCM Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups for more information about this data.

Best Practices for Clinical Quality Measures
Race, Hispanic ethnicity, language, and country of origin data collection undergoes a unique validation process to ensure that medical groups collect these data elements from patients using best practices. Best practices are defined as:
1. Patients self-report their race and Hispanic ethnicity.
2. Patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multi-racial category).
3. Medical groups/clinics have the ability to capture and report more than one race as reported by the patient.

A medical group/clinic must meet all the criteria for each data element to achieve best practice status and to have their data included in the rate calculation. Only validated data, collected using best practices, are used to calculate rates by race, Hispanic ethnicity, language, and country of origin.